Negative Pressure Wound Therapy (NPWT)

Coverage Position

Coverage for NPWT and accessories is subject to the terms, conditions and limitations of this policy.

NPWT is considered medically necessary when the patient meets the following criteria categorized according to: 1) Participation in a complete wound care program AND 2) Presence of eligible conditions.

I. Participation in a complete wound care program:

A complete wound care program must have been implemented for at least 30 days (counting nursing home and hospital days) or ruled out based on specific contraindications (with specific documentation as to why it was ruled out) prior to the addition of vacuum assisted wound therapy. Such a wound care program should include ALL of the following:

* Documentation in the patient's medical record of presence/adequacy of granulation tissue and wound measurements (length, width, and depth) by a licensed medical professional (LPN, RN, CRNP, or PA-C) weekly and by Mid Level provider (CRNP, or PA-C) or physician at least monthly, and
* Documentations of application of dressings to maintain a moist environment (or why that is not appropriate), and
* Documentation patient's moisture and incontinence, if any, have been appropriately managed by frequent bed changes, skin creams as indicated per physician, indwelling catheter as indicated per physician, and
* Documentation of debridement of necrotic tissue if present, and
* Documentation that there is no cancer in the wound, and
* Documentation of provision of appropriate diet for underlying medical condition, and
* Documentation that all underlying medical conditions have been stabilized or are under a current management plan including appropriate diet, medications if indicated, elevation of bed if indicated, etc., and
* Documentation of relief of pressure on the wound with appropriate support surfaces and positioning/turning, and
* Documentation of how long the complete wound care program has been in place before NPWT was started.

II. Eligible condition (patient must meet ONE of the following);

- There are complications of a surgically created wound (e.g. dehiscence, post-sternotomy disunion with exposed sternal bone, post-sternotomy mediastinitis, or postoperative disunion of the abdominal wall)

- There is a traumatic wound (e.g. preoperative flap or graft, exposed bones, tendons, or vessels)
- There is a chronic, non-healing ulcer with lack of improvement in spite of complete wound care program (described in section I) in **one** of the following clinical situations:

1. Chronic Stage III or Stage IV pressure ulcer (see notes below regarding staging system) with documentation of a, b, **and** c.
    a. The patient has been on an appropriate turning and repositioning regimen.
    b. The patient has used an appropriate pressure relief device (e.g. low air loss bed or alternating pressure redistribution mattress) for pressure ulcers on the posterior trunk or pelvis
    c. The patient's moisture and incontinence have been appropriately addressed.
2. Chronic neuropathic ulcer (e.g. diabetic) with documentation of a, b, **and** c.
    a. The patient has been on a comprehensive diabetic management program including diet and medications (if indicated).
    b. The patient has had appropriate foot care including podiatry or orthopedic or general surgery consultation if ulcer is on the foot.
    c. The patient has been compliant with non-weight bearing instructions when appropriate.
3. Chronic venous ulcer with documentation of the following
    a. Compression garments/dressings have been consistently applied if tolerated by the patient
    b. Leg elevation and ambulation have been appropriately encouraged.

Medicaid will cover medically necessary NPWT for up to 3 consecutive months, including any time during which NPWT was applied in an inpatient setting prior to discharge to the nursing home. This would not prevent using NPWT again if patient developed eligible conditions at a later time AND the above noted criteria were met.

Medicaid will cover NPWT for "unavoidable" pressure ulcers that have developed in the nursing home, **when Medicaid determines that the medical documentation provided indicates the following:**

1. Eligible condition developed even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors
2. Participation in a complete wound care program (defined in section I. above)
3. Interventions have been monitored and evaluated.
4. Approaches revised when ineffective and still failed to be effective.

Medicaid will not cover NPWT in the home setting.

Medicaid does not cover NPWT for non-healing wounds or ulcers under any of the following conditions because it is considered not medically necessary (this list may not be all-inclusive):

- Appropriate licensed medical personnel (LPN, RN, CRNP, or PA-C) are not performing and documenting weekly wound measurement and assessment functions as well as the negative pressure wound therapy dressing changes as required.
- Physician or CRNP or PA-C are not performing and documenting at least monthly evaluations of the wound.
- Facility staff not adequately trained and equipped to correctly utilize NPWT.
- Patient is terminal or in hospice care.
- Wound healing has occurred to the extent that negative pressure wound therapy is no longer necessary as determined by the physician or CRNP or PA-C.
- Uniform granulation tissue has been obtained.
- The patient cannot tolerate the use of NPWT.
- The wound is infected or patient has underlying osteomyelitis and patient is not under medical and/or surgical treatment for the infection
- There is no progression of healing of the wound during two weeks of NPWT dressing changes.
- In cases of abdominal wound dehiscence, bowel is present in the wound.

Staging system typically used for pressure ulcers measures tissue destruction by classifying wounds according to the tissue layers involved. The National Pressure Ulcer Advisory Panel Statement on Reverse Staging of Pressure Ulcers describes the stages as follows (2003):

Stage 1: Pressure ulcer is an observable, pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following : skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.
Stage2: Partial-thickness skin loss involves epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.
Stage 3: Full thickness skin loss involves damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage 4: Full thickness skin loss has extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts may also be associated with Stage 4 pressure ulcers.

Contraindications for NPWT:

- active bleeding
- anticoagulant use
- difficult wound hemostasis
- presence of necrotic tissue with eschar, if debridement is not attempted
- untreated osteomyelitis within the vicinity of the wound
- malignancy in the wound
- unexplored fistula
- untreated malnutrition
- exposed vital organs
- patient non-compliant with NPWT.
- Pain from NPWT which is unrelieved by medication or alternative measures

Checklist for reviewers re NPWT:

Documentation of the following must be present:

1. Assessment of evaluation, care, presence/adequacy of granulation tissue, and wound measurements (length, width, and depth) by a licensed medical professional (LPN, RN, CRNP, or PA-C) weekly and by Mid Level provider (CRNP, or PA-C) or physician at least monthly
2. Application of dressings to maintain a moist environment (or why that is not appropriate)
3. Assessment of patient's moisture and incontinence, if any, have been appropriately managed by frequent bed changes, skin creams as indicated per physician, indwelling catheter as indicated per physician.
4. Debridement of necrotic tissue if present
5. No malignant cells (cancer) in the wound
6. Assessment and provision of appropriate diet for underlying medical condition
7. All underlying medical conditions have been stabilized or are under a current treatment plan
8. Relief of pressure on the wound with appropriate support surfaces and positioning/turning
9. Complete wound care program (see section I) must have been in place at least 30 days counting nursing home and hospital days.
10. Presence of and eligible condition (see section II)
11. If diabetic, patient is on comprehensive diabetic management program (diet and medications-if indicated) and has had appropriate foot care. If ulcer is on foot must have consult from podiatry, orthopedics, or general surgery.
12. Patient is compliant with NPWT
13. For chronic venous ulcers: compression garments/dressings have been consistently applied, if tolerated, and leg elevation and ambulation have been appropriately encouraged
14. Facility staff adequately trained and equipped to correctly utilize NPWT
15. Patient is not terminal or in hospice care
16. NPWT stopped when adequate (as judged by the physician or Mid level provider) granulation tissue has formed.
17. If wound is infected or patient has underlying osteomyelitis, then patient must be under medical and/or surgical treatment for the infection.
18. Wound is improving every two weeks.
19. In cased of abdominal wound dehiscence no bowel is present in the wound
20. Contraindications (see policy) are not present